MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Sierra Medical Center #004968336 P.O. Box 809053 Dallas, TX 75380	MDR Tracking No.: M4-03-9688-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance c/o Hammerman & Gainer Box 28	Date of Injury: Employer's Name: Raytheon Co. Insurance Carrier's No.: 949692328

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/27/02	08/29/02	Inpatient Hospitalization	$61,227.78	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

A Position Summary was not submitted; however, the Requestor's rationale on the Table of Disputed Services states, "Carrier remitted $4,511.75 to the provider herein requesting a dispute resolution. The carrier paid the per diem rate of $1,118.00 for a 2-day uninterrupted stay. The carrier also paid 100% of the implants charges at revenue code 278 which were $2,275.00. The carrier totally ignored the stoploss rule set forth by the Commission in Rule 134.401(6). Even in applying the recent SOAH ruling in subracting (sic) the charge for the implants it would still leave the charges as qualifying for the stoploss. Therefore, provider hereby seeks an order from the Commission for the carrier to pay the additional amount of $61,277.78…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "…Upon conduting a line by line audit, it was determined that revenue code &2700 on itemization had a billed charge of $65,472.00. The provider billed 768 Cath IV placements. Allowed 10 Cath IV placements at $85.28 each - $852.80 and denied remaining $64,619.20 with x322 as need documentation to support this extraordinary charge. Documentation was not submitted to support this charge with the original billing or the appeal…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 2 days (consisting of 2 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $2,236.00 (2 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit implant invoices; therefore, MDR cannot determine the cost plus 10%.

The Requestor billed the Respondent $87,652.70 and received payments totaling $4,511.75. Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Marguerite Foster	03/22/03
Authorized Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____